Patient's Name: ________________________________ **Date:**_________________

DYSPNEA

Normal • Have you had any previous breathing difficulties?	
Onset • When did your difficulty in breathing start? • Did it start suddenly or gradually over the last few days? • How long does it last? • How often does it occur? • Has it changed your activity level?	
Provoking / Palliating • What brings it on? • Makes it worse? (e.g. SOBOE, ADL's, emotions) • What makes it better? (e.g. positioning)?	
Quality (in last 24 hours) • How does it feel when you are breathless? (e.g. pain, air hunger, gasping, panting)	
Region / Radiation – N/A	
Severity / Other Symptoms • How bothersome is this symptom to you? (scale of 0 – 10, with 0 not at all and 10 being worst imaginable) • Do you have other symptoms such as pain, fatigue, anxiety, worry, or depressed mood? • Cough, sputum, fever, chills, hemoptysis, chest tightness, palpitations, light-headedness?	
Treatment • What medications or treatments are you using or have used in the past? • How effective are they? Any side effects?	
Understanding / Impact on You • Is shortness of breath affecting your mood? • What activities are you unable to do because of it? • Are you able to sleep at night? Do you have to prop up on pillows to sleep? • How does this affect your family?	
Value • Why do you believe you are short of breath? • What is your comfort goal or acceptable level for this symptom (0 – 10 scale)? • How are you hoping we can help you?	

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